U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 24 September 2004

Case No. 2003-BLA-6405

In the Matter of

BEN L. STEPHENSON,
Claimant,

v.

ISLAND CREEK COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

John Cline, Esquire,
For the Claimant

Ashley Harman, Esquire,
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claimant's subsequent claim after a denial of his prior claims for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. (the Act). DX 1. The Act and implementing regulations, mainly 20 C.F.R. Parts 410, 718, and 727 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis or CWP) as a chronic dust disease of the lungs and its

sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

PROCEDURAL HISTORY

Claimant filed his first claim for benefits with the Department of Labor (DOL) on August 9, 1974; that claim was denied on September 10, 1974, by a DOL claims examiner. DX 1. A second claim was filed on July 31, 1984. Because it was filed more than one year after the prior denial, it was considered a duplicate claim to be governed by § 725.309(d). That claim was denied by Administrative Law Judge (ALJ) Frank J. Marcellino on April 18, 1988 for failure to establish total disability. DX 1. Judge Marcellino credited the miner with thirty years of coal mine employment pursuant to the parties' stipulation and found that Mr. Stephenson had established the existence of pneumoconiosis pursuant to the x-ray evidence.

Claimant took no further action until he filed the current claim on August 21, 2001. DX 3. Because it was filed more than one year after the prior denial, it is a subsequent claim governed by § 725.309. The District Director issued a Proposed Decision and Order on April 23, 2003, in which he denied the claim for failure to establish that the Claimant's pneumoconiosis was caused, at least in part, by coal mine employment or that Claimant has a totally disabling respiratory impairment. DX 34. On May 15, 2003, Claimant objected to the findings of the District Director and requested a formal hearing before an ALJ. DX 36.

On January 23, 2004, I held a hearing in Charleston, West Virginia. The Claimant and Employer, both represented by counsel, were afforded the full opportunity to present evidence and argument. I admitted Director's exhibits 1–41, Claimant's exhibits 1–7, and Employer's exhibits 1–6 and 10–12 into the record. TR 5, 14, 31–36. I sustained the Claimant's objections to proposed EX 8 and 9, x-ray readings by Drs. Bellotte and Zaldivar, respectively, for exceeding the evidentiary limits. TR 35. I also sustained the Claimant's objection to proposed EX 13, Dr. Wiot's interpretation of the December 4, 2003 CT scan for the same reason. TR 38–39. The Employer was permitted to submit post-hearing the supplemental reports of Drs. Zaldivar and Bellotte after reviewing Dr. Wiot's reading of the July 7, 2003 X-ray. TR 31. Those two reports, Dr. Zaldivar's dated April 2, 2004, and Dr. Bellotte's dated February 18, 2004, are received into evidence as EX 14 and EX 15, respectively. The Claimant was permitted to submit post-hearing the supplemental report of Dr. Rasmussen, responding to the supplemental opinions of Drs. Bellotte and Zaldivar. TR 40. That report, dated February 10, 2004, is admitted as CX 8.

The Employer was allowed to argue good cause for the submission of EX 7, Dr. Wiot's December 5, 2003 reading of the November 2, 2001 X-ray initially read by Dr. Walker for the OWCP. TR 33-34. The reading was not proffered to the Claimant until January 12, 2004, just nine days prior to the hearing. Thus, it violates the "twenty-day rule" set forth at § 725.456. At the hearing, the Employer argued that it requested the OWCP to forward the film to Dr. Wiot in a timely fashion but that office did not do so in time to get the report timely submitted. TR 33. In its brief, the Employer adds that it requested the film of the OWCP on November 25, 2003. It further contends that although Dr. Wiot read the X-ray on December 5, 2003, the Employer's counsel's "date-received" stamp shows it did not receive that report until January 8, 2004. The

Employer also avers that in its evidence summary form of January 2, 2004, it listed Dr. Wiot as a reviewer of the film, thus negating any surprise to the Claimant. The Employer alleges it did not intentionally withhold the report. Lastly, the Employer states that the Claimant could also have had the film reread.

I will first note that the evidence summary form submitted by the Employer and dated January 2, 2004, does list a proposed employer's exhibit of the November 2, 2001 X-ray as rebuttal of the Department-sponsored X-ray. In a footnote, the Employer stated, "On 25 November 2003, Island Creek Coal Company requested the DOL/Parkersburg, WV send the 2 November 2001 DOL film to the University of Cincinnati for rebuttal readings. To the best of our knowledge, the DOL has not yet forwarded this film as requested. This rereading will be submitted as soon as possible."

Twenty C.F.R. § 725.456(b) states that no documentary evidence, including medical reports, shall be admitted if not provided to all other parties at least twenty days before the hearing. However, 20 C.F.R. § 725.456(b)(2) (2000) and 20 C.F.R. § 725.456(b)(3) (2001) allow the ALJ, at his discretion, to admit documentary evidence that is late if the parties agree or if "good cause" is shown. *Newland v. Consolidation Coal Co.*, 6 BLR 1-1286 (1984). I find instructive the Fourth Circuit's holding in *Bethlehem Mines Corp. v. Henderson*, 939 F.2d 143 (4th Cir. 1991), in which it stated:

> An obvious purpose of the twenty-day rule is to prevent unfair surprise. . . . [W]e caution that neither the APA nor considerations of due process should be understood as providing a license for a dilatory party to delay preparation and timely submission of its affirmative case. The APA makes clear that a party is only entitled to such rebuttal "as may be required for a full and true disclosure of the facts."

In this case, the X-ray in question was taken November 2, 2001. Employer had Dr. Bellotte read the film on February 23, 2002 but chose not to submit that reading because it favors the Claimant. (Rather, the Claimant submitted it as part of his evidence.) This fact demonstrates that the Employer had received the X-ray in ample time to have it read by a physician of its choosing. That Dr. Wiot did not read the X-ray until December 5, 2003, and that the Employer did not receive the reading until January 8, 2004, tends to demonstrate "at best a self-inflicted wound," *id.* at 147, rather than a disadvantage created by dilatory actions of the OWCP. Consequently, I do not find that the Employer has established good cause for the admission of proposed EX 7. Therefore, I sustain the Claimant's objection to EX 7 and exclude it from evidence.

The parties stipulated to Employer's proper designation as the Responsible Operator, to thirty years of qualifying coal-mine employment by the Claimant, and to the qualification of one dependent, Claimant's wife Nora, for purposes of augmentation of benefits. TR 11–12.

ISSUES

(1) Whether the evidence establishes a change in a condition of entitlement pursuant to 20 C.F.R. § 725.309(d), and if so:
(2) Whether the miner has pneumoconiosis;
(3) Whether the miner's pneumoconiosis arose out of his coal mine employment;
(4) Whether the miner is totally disabled; and
(5) Whether the miner's disability is due to pneumoconiosis.

FINDINGS OF FACT

Length of Coal Mine Employment

The parties agree and I find that the evidence of record establishes that the Claimant was a coal miner within the meaning of the Act and Regulations for at least thirty years. TR 11.

Date of Filing

Claimant filed his current claim on August 21, 2001, more than one year after a claims examiner denied his previous claim on April 18, 1988. DX 3. I find that Claimant timely filed the present claim pursuant to 20 C.F.R § 725.309.

Responsible Operator

The parties agree and I find that Island Creek Coal Company is the last employer for whom the Claimant worked a cumulative period of at least one year. Therefore, Employer is the properly designated responsible coal mine operator in this case.

Dependents

I find that Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Nora Lee Smith Stephenson. DX 10; TR 17.

Personal, Employment and Smoking History

The Claimant was born on December 8, 1922. DX 3. He testified that he worked as a coal miner for thirty-three years, twenty-four of which were with Employer. TR 15. All of the work was underground. He last worked on April 3, 1984, quitting because of arthritis. From 1957 to 1972, he ran a miner, a bolt machine, a drilling machine, and a shuttle car. He also drilled rock. His last years in the mines were as a foreman, requiring him to walk five miles per shift. TR 19–20. This included walking in the return airways, so he was exposed to considerable dust. He testified that walking the airways was the hardest part of his job. TR 29. He has not worked since. TR 21.

Mr. Stephenson uses oxygen twenty-four hours a day. TR 17. He began using oxygen in 2001, when his physician, Dr. Wesley Olson, prescribed it. Mr. Stephenson testified that he still coughs and spits up in the morning. He takes Albuterol and Prednisone, among many other medications, and finds that these help. TR 22. The Claimant began to slow down in 1983, when he noticed that he had to rest while on a walk. TR 26–27. He underwent a coronary artery bypass graft (CABG) in 1999, and now can walk only about seventy-five feet without resting. TR 29–30.

Mr. Stephenson testified that he began smoking sometime between 1942 and 1945 and quit in 1975. He did not smoke while in the mines and estimated that he smoked eight to ten cigarettes a day. TR 23. He also chewed tobacco. He stated that Dr. Bellotte got his smoking history wrong, and that if the miner completed a form stating that he smoked one pack of cigarettes a day, it was an unintentional error. TR 24–25.

Medical Evidence

Chest X-rays

Exhibit No.	**X-ray Date**	**Physician/ Qualifications**	**Interpretation**
DX 1	8/24/73	Gaylor/BCR, B	0/0
DX 1	8/24/73	*Illegible*	0/0
DX 1	9/14/78	Kwak/BCR	1/1
DX 1	12/1/80	Hayes/B	Mild diffuse nodular fibrosis consistent with occupational pneumoconiosis
DX 1	12/22/80	Goerlich/BCR, B	1/1
DX 1	8/29/84	Gaziano/B	Completely negative
DX 1	8/29/84	Daniel	2/2
DX 1	12/13/84	Bassali/BCR, B	3/3
CX 2-5	12/13/99	Shah/BCR	Severe degree of chronic obstructive pulmonary disease and pulmonary fibrosis
CX 2-4	3/20/01	Amin/B	Status post-CABG with severe chronic obstructive lung disease. Diffuse, fine honeycombing in both lung bases and periphery of lungs from small airway disease
CX 2-3	4/2/01	Amin/B	Status post-CABG with severe chronic obstructive lung disease; diffuse fine reticular nodular fibrosis in both lungs predominant in left periphery of left lung

CX 2-2	10/23/01	Amin/B	Status post-CABG with chronic obstructive lung disease. Diffuse, fine interstitial fibrosis is noted in both lungs from COLD
DX 14	11/2/01	Walker	2/2; p/q
DX 17 & 18	11/2/01	Hayes/BCR, B	2/2; p/q; 6 zones; post bypass surgery; areas of fibrosis in both lower lung zones
CX 5-2	11/2/01	Bellotte/B	1/2; t/q; 6 zones; status post coronary artery bypass graft; pulmonary fibrosis
CX 2-1	4/19/02	Maki	Significant underlying lung disease; left cardiac enlargement and mild prominence of interstitial markings. May be some underlying congestive heart failure
CX 1	3/28/03	Maki	Significant pulmonary fibrosis with COPD and emphysematous change; chronic bronchitis is also likely present
CX 5-1	7/7/03	Bellotte/B	1/2; q/q; 6 zone; status post-CABG; increased interstitial markings, pulmonary fibrosis, left pleural thickening
EX 5[1]	7/7/03	Wiot/BCR, B	Negative for pneumoconiosis; post-CABG; basilar and mid zone interstitial disease, not CWP. Honeycombing at left base; irregular opacity primarily in bases. Findings of emphysema.
EX 3	11/5/03	Zaldivar	Negative for pneumoconiosis; post-CABG; combined bullae and irregular opacities with honeycombing of pulmonary fibrosis.
EX 5	11/5/03	Wiot/BCR, B	Negative for pneumoconiosis; post-CABG; basilar and mid zone interstitial disease, not CWP. Honeycombing at left base; irregular opacity primarily in bases. Findings of emphysema.

[1] Dr. Wiot provided this explanation of his findings regarding the 7/7/03 and 11/5/03 films: "Pneumoconiosis is not a cause of basilar interstitial fibrosis. CWP invariably begins in upper lung fields and is primarily a rounded opacity. Only when the disease progresses does it move to the mid and lower lung fields."

Pulmonary Function Studies[2]

Exh.#	Date	Age/Height	FEV1	MVV	FVC	Qualify?	Impression
DX 16	11/2/01	78/65.25"	2.10		2.76	No	Normal
EX 1	7/7/03	80/65"	1.77 1.83*		2.38 2.61*	No	Mild obstructive vent. impairment
CX 1	7/22/03	80/68"	2.04 1.93*	52 49*	2.76 2.70*	No No	Pulmonary fibrosis; minimal improvement after bronchodilator
EX 3	11/5/03	80/65"	1.99 2.03*		2.84 3.00*	No	
CX 4	12/16/03	81/63"	2.10	43	3.05	No	Normal

Arterial Blood Gas Studies

Exh.#	Date	pCO2	pO2	Qualify?	Impression
DX 13	11/18/99	36	76	No	
DX 15	11/2/01	39	79	No	
EX 1	7/7/03	42.2	51.4	Yes	Severe impairment of pulmonary gas exchange
CX 1	7/22/03	44.6	63.9	No	Hypoxemia
EX 3	11/5/03	42	52	Yes	

[2] An asterisk (*) indicates a post-bronchodilator value. A "qualifying" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718. A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

For a miner 65.25 inches in height to have a qualifying result under the Regulations, § 718.204(c)(1) requires an FEV1 equal to or less than 1.48 for a male seventy-eight years of age. If such an FEV1 is shown, there must be in addition an FVC equal to or less than 1.92 or an MVV equal to or less than 59; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV1/FVC ratio requirement remains constant.

Height	Age	FEV1	FVC	MVV
65.25"	80	1.48	1.92	59
65"	80	1.48	1.92	59
68"	80	1.73	2.24	69
63"	81	1.32	1.73	53

CT Scan Evidence

The Claimant underwent a CT scan of the chest on December 4, 2003. Dr. Manu Patel interpreted that scan and found diffuse interstitial lung fibrosis with honeycombing of the lungs, indicating end-stage pneumoconiosis; bilateral extensive bullous emphysema; likely chronic adenopathy associated with pneumoconiosis; and prior coronary artery bypass surgery. CX 3.

Dr. Wiot, who is board certified in radiology, read the CT scan and found no evidence of coal workers' pneumoconiosis. He noted previous coronary bypass surgery, diffuse interstitial fibrosis most prominent in the bases and mid zones and also present in the upper lung fields but to a significantly less degree. Dr. Wiot further stated that the changes were irregular in nature and associated with traction bronchiectasis and honeycombing. He saw a few bullae, which, he added, are not a manifestation of coal dust exposure. Dr. Wiot opined that there are multiple causes of basilar interstitial fibrosis but that coal workers' pneumoconiosis is not one of them. He added that the most likely causes of these findings are UIP and IPF.

Physicians' Reports

The record contains records from Monongalia General Hospital from July 25, 1988 through December 15, 1999. DX 13. In 1988, Mr. Stephenson suffered from angina pectoris and a myocardial infarction. He was diagnosed with coronary artery disease, high blood pressure, and, following an angioplasty, stable coronary disease. The records indicate that he quit smoking in 1975 and that his chest was clear upon examination. In April 1993, the miner suffered again from angina and underwent a coronary angioplasty. He was diagnosed with two-vessel coronary artery disease. In November 1999, the claimant underwent CABG. It was noted that he had a history of cerebrovascular accident leading to left-sided paralysis in 1997. Once again, the lungs were clear. A smoking history of one pack of cigarettes a day for forty years before quitting in 1974 was provided. Attending physicians diagnosed coronary artery disease and congestive heart failure.

Also in the record are records from Summerville Memorial Hospital from March 2, 1999 through February 5, 2001. EX 12. Mr. Stephenson complained of arthritis, chest congestion, weakness, and an occasional cough. The records are not otherwise helpful.

On November 2, 2001, James H. Walker, M.D., examined the Claimant. DX 14. Dr. Walker noted that Mr. Stephenson had worked thirty-three years in the coal mines, lastly as a foreman. During the examination Dr. Walker conducted an x-ray, an EKG, a blood gas study, and a pulmonary function study. Both the arterial blood gas study and pulmonary function studies were interpreted as normal. Dr. Walker also considered a medical history of frequent colds, pneumonia, pleurisy, wheezing, arthritis, heart disease, allergies, hypertension, a stroke, an angioplasty, CABG, and the need to be on oxygen. He was given a history of smoking three-quarters of a pack of cigarettes a day for twenty years, ending in 1966, and thirty-three years of coal mine employment, lastly as a foreman. Mr. Stephenson complained of a productive cough, wheezing, shortness of breath, chest pain, and orthopnea. Physical examination revealed suppressed and harsh auscultation. Based on his examination, Dr. Walker diagnosed coal

workers' pneumoconiosis and arteriosclerotic cardiovascular disease post-CABG, both due to occupational dust and tobacco abuse. He did not address the issue of impairment.

The Employer submitted the report of John A. Bellotte, M.D., dated July 7, 2003. EX 1. Dr. Bellotte noted complaints of shortness of breath, wheezing, a productive cough, chest pain, and ankle edema. Dr. Bellotte noted Mr. Stephenson had worked thirty-three years in the coal mines, lastly as a foreman. He also considered a smoking history of between one-half and one pack of cigarettes a day for twenty years, quitting in 1975.

Dr. Bellotte conducted a pulmonary function study and a blood gas study. The blood gas study showed a severe impairment of pulmonary gas exchange, and the pulmonary function study evinced a mild obstructive ventilatory impairment. Physical examination revealed rales.

Dr. Bellotte also reviewed all the medical records dating from 1973 to 2001. He diagnosed pneumoconiosis and opined that the miner is totally and permanently disabled from performing coal mine employment due to coronary artery disease and congestive heart failure, stroke, myocardial infarction, angiograms, angioplasties, and bypass surgery. He detected no pulmonary or respiratory impairment related to pneumoconiosis. In his opinion, the medications Mr. Stephenson takes for his heart disease may contribute to his respiratory symptoms and cause cough, wheezing, and shortness of breath. Dr. Bellotte averred that longitudinal studies show that the miner has retained normal pulmonary function and blood gas studies long after retirement. Dr. Bellotte is Board-certified in internal medicine and pulmonary disease. EX 2.

Dr. Bellotte was deposed on January 16, 2004. EX 11. He provided his credentials, reviewed the results of his examination, and reviewed the reports and objective studies of Drs. Zaldivar and Rasmussen. He testified that one can see gas transfer abnormalities with pneumoconiosis. He noted that the miner had given different smoking histories over the years, up to 30–40 years of smoking. He attributed the miner's ankle edema to his congestive heart failure. Dr. Bellotte agreed with the conclusions reached by Drs. Zaldivar and Rasmussen regarding the pulmonary function studies. All were consistent with congestive heart failure and showed that from a purely ventilatory standpoint—the ability to get air in and out of the lungs—the miner retains the capacity to perform manual labor. He added that all three studies showed severe impairment of the ability for gas exchange, known as diffusion capacity, due to chronic congestive heart failure and interstitial pulmonary fibrosis.

Based on the CT scan, Dr. Bellotte did not believe that the etiology of the interstitial fibrosis is pneumoconiosis because more lesions were seen in the bases of the lungs, whereas pneumoconiosis causes abnormalities in the upper zones. He added that honeycombing, as shown on the CT scan, is not seen in pneumoconiosis but is typical of idiopathic pulmonary fibrosis (IPF), which occurs in the general population. He did not think that IPF occurs more often in coal miners but said that maybe West Virginia sees more IPF because of its coal mining population. Dr. Bellotte reviewed the McConnochie article cited by Dr. Rasmussen. He testified that it documents incidents of pulmonary fibrosis in coal miners but it states that it is unknown whether pulmonary fibrosis can be caused by coal dust inhalation. Dr. Bellotte opined that it is more difficult to differentiate asbestosis from pulmonary fibrosis on X-ray because both cause linear abnormalities.

Dr. Bellotte stated that he does not believe Mr. Stephenson's pulmonary fibrosis is due to his coal mine employment because his 1984 X-ray was negative for pneumoconiosis, even though he accepted that pneumoconiosis can be latent and progressive. He added, however, that it is much more latent and progressive when the disease is category 2 or 3. Dr. Bellotte opined that Mr. Stephenson would be just as disabled if he had never been a coal miner. He also diagnosed bullous emphysema due to smoking, stating that smoking and pulmonary fibrosis are causes of gas exchange problems. He believed that the miner's pulmonary fibrosis is idiopathic but suspects both chronic infections and chronic recurrent bouts of congestive heart failure may be to blame. He was able to rule out pneumoconiosis as a cause because there is no data that pulmonary fibrosis is seen more frequently in coal miners.

In a letter dated February 18, 2004, Dr. Bellotte provided his comments after being informed of Dr. Wiot's reading of the July 7, 2003 X-ray. EX 15. Dr. Wiot's finding did not change any of Dr. Bellotte's opinions.

The Claimant submitted a August 12, 2003 letter written by Wesley Olson, M.D., his family practitioner. CX 1. The letter refers to X-rays confirming significant pulmonary fibrosis with chronic obstructive pulmonary disease and emphysematous changes; an EKG and echocardiogram that showed left atrial enlargement with an ejection fraction of 60% and mild pulmonary hypertension, both of which he opined could be secondary to pulmonary fibrosis; a pulmonary function study that showed pulmonary fibrosis with minimal improvement with bronchodilation; and a blood gas study that evinced hypoxemia. He felt this data points to pulmonary fibrosis as opposed to a reactive airway disease. He felt the X-ray findings of pulmonary fibrosis could be due to pneumoconiosis and opined that pulmonary fibrosis can be secondary to pneumoconiosis or occupational lung exposure.

Dr. Olson was deposed on January 5, 2004. EX 10. He is Board-certified in family practice and testified that he began treating Mr. Stephenson in 1999. He sees him every three to six months, following him for respiratory infections, congestive heart failure, anemia, hypertension, coronary disease, and pulmonary disease. Dr. Olson considered Dr. Rasmussen's December 2003 report. He stated that he has diagnosed pulmonary fibrosis, chronic obstructive pulmonary disease, and emphysematous changes based on X-rays and his physical findings such as hyperresonant lungs, increased expiratory sounds, some wheezing, and a prolonged expiratory flow rate. Dr. Olson testified that he would defer to pulmonary specialist but he thinks that the three diagnosed conditions are due to smoking and occupational dust exposure, as the miner quit smoking in 1975. He was not aware of the exertional rigors of the miner's last job or the date when he left coal mine employment; nor did he claim to know the cause of the miner's hypoxemia.

Dr. Olson testified that he prescribed oxygen for the Claimant on April 2, 2001. While he does not read X-rays or interpret pulmonary function study results himself, he felt that Mr. Stephenson has findings compatible with pneumoconiosis, namely hypoxemia and pulmonary fibrosis. He admitted, however, that he does not know if honeycombing is typical of pneumoconiosis or if it is a latent and progressive disease.

Employer engaged George L. Zaldivar, M.D., to examine Mr. Stephenson on November 5, 2003. EX 3. Dr. Zaldivar considered a medical history of myocardial infarction, open-heart surgery, and angioplasty. He noted symptoms of shortness of breath for five years but not much since being on oxygen, wheezing for four years, cough with sputum, and the need to sleep on two pillows. Dr. Zaldivar considered a history of smoking one-half pack of cigarettes a day for thirty years before quitting in 1975 and thirty-three years of coal mine employment, lastly as a foreman. Physical examination showed fine inspiratory crackles. He also reviewed the results of a pulmonary function study and a blood gas study. Dr. Zaldivar diagnosed a history of pulmonary fibrosis, a history of shortness of breath due to pulmonary fibrosis, and coronary artery disease with angina present during any kind of activity.

Dr. Zaldivar reviewed the letter from Dr. Olson, an EKG report, hospital records, the echocardiogram results, and pulmonary function studies, blood gas studies, and X-rays taken between 1973 and 2003. In his opinion, there was no evidence to justify the diagnosis of CWP or dust disease of the lungs. Dr. Zaldivar believes that the miner suffers from a severe pulmonary impairment due to pulmonary fibrosis unrelated to coal mine employment. He described the fibrosis as a disease of the general population. Dr. Zaldivar additionally found coronary artery disease causing mild dysfunction of the heart, which he found to be disabling itself because of the accompanying angina. He stated that this condition is unrelated to coal mine employment. In summary, Dr. Zaldivar opined that Mr. Stephenson is disabled due to cardiac disease and pulmonary fibrosis. Even if the miner were found to have pneumoconiosis, his opinion regarding disability and its causation would remain unchanged because when pneumoconiosis causes impairment, it is chronic obstructive pulmonary disease, which he does not believe the miner has. Dr. Zaldivar is Board-certified in internal medicine, pulmonary disease, and sleep disorder medicine. EX 4.

The Claimant submitted the report of Dr. D.L. Rasmussen, who examined him on December 16, 2003. CX 4. He noted symptoms of shortness of breath since the 1970s, worsening since 1996, a chronic productive cough, wheezing, the need to sleep on two pillows, the need for oxygen therapy, ankle swelling, and chest pain with exertion. A medical history was significant for a myocardial infarction in 1986, two angioplasties, CABG, hypertension, pneumonia, and pleurisy. He gleaned a smoking history of five to six cigarettes a day for thirty-one years before quitting in 1975 and a coal mine employment history of thirty years as a general laborer, lastly as a mine foreman. Dr. Rasmussen set forth the exertional requirements of the miner's jobs and learned that he last worked as a miner in 1984.

Physical examination showed tubular breath sounds and many Velcro inspiratory crackles in the mid lung zones. He ordered a pulmonary function study that was considered normal. Additionally, Dr. Rasmussen reviewed the reports of Drs. Daniel, Rectenwald, Zaldivar, and Bellotte, the letters from Drs. Olson and Porterfield, two x-rays, a CT report, and hospital records. Dr. Rasmussen diagnosed end-stage pneumoconiosis. He concluded that the miner has a severe, totally disabling chronic lung disease according to the diffusing capacity values, and set forth three causes for the disabling lung disease: cigarette smoking, coal dust exposure, and interstitial fibrosis.

Dr. Rasmussen opined that coal dust exposure causes findings of significant impairment in oxygen transfer absent ventilatory impairment and cited a medical article for support of this proposition. He also averred that diffuse interstitial pulmonary fibrosis is considerably more common in coal miners than the general population. He cited the article by McConnochie in support of this statement. Dr. Rasmussen stated both that the interstitial fibrosis is most likely at least partially due to the Claimant's coal mine dust exposure and that his total disability is primarily due to coal dust exposure. Dr. Rasmussen is Board-certified in internal medicine and forensic medicine. CX 6.

Dr. Zaldivar was deposed on January 20, 2004. EX 12. He described the Claimant's last coal mining work as mild to moderate labor. He testified that crackles are not an expected finding with pneumoconiosis and that honeycombing is typical of pulmonary fibrosis. He stated that the ventilatory study showed no abnormality, thus the miner does not have an airway obstruction. Dr. Zaldivar testified that Mr. Stephenson's total lung capacity was mildly reduced because of the pulmonary fibrosis. He also asserted that the very low diffusion capacity was typical of pulmonary fibrosis, scarring of the lungs that prevents passage of gases from the air spaces to the blood spaces. He also stated that CWP "never causes pulmonary fibrosis, so it's not even in the differential diagnosis." He opined that Mr. Stephenson's disease was most likely idiopathic.

Dr. Zaldivar further stated that the CT scan confirmed the x-ray findings of pulmonary fibrosis. He disagreed with Dr. Patel's interpretation and added that only asbestosis resembles the linear findings of pulmonary fibrosis; CWP does not. However, because the pleural thickening was unilateral, the probable cause was heart surgery, not asbestos exposure, which causes bilateral thickness. Furthermore, Dr. Zaldivar pointed out that the miner's pulmonary function studies show restrictive and diffusion impairment, neither of which is present in pneumoconiosis. The blood gases had markedly deteriorated since 2001. He felt that neither the pulmonary function nor the blood gas studies were compatible with CWP. While he found a severe pulmonary impairment that is totally disabling, Dr. Zaldivar related it to pulmonary fibrosis and not pneumoconiosis. He disagreed with Dr. Olson's opinion that pneumoconiosis contributes to pulmonary fibrosis and further stated that Dr. Rasmussen's allegation is not backed by the medical literature, including the article by McConnochie that he cited. Dr. Zaldivar explained that the article's authors said that some coal miners have pulmonary fibrosis and that they need to be studied further. The article did not propose to prove anything regarding the association between coal dust exposure and pulmonary fibrosis. He went so far as to opine that fibrosis is never a manifestation of CWP unless it is massive pulmonary fibrosis. Finally, Dr. Zaldivar stated that Mr. Stephenson does not have COPD because he has no obstruction.

Dr. Zaldivar provided a letter dated February 2, 2004, in which he reviewed Dr. Wiot's reading of the November 5, 2003 x-ray. EX 14. He agreed with his finding of no pneumoconiosis but the presence of pulmonary fibrosis. Dr. Zaldivar's previous opinions remained unchanged.

Dr. Rasmussen provided a further opinion on February 10, 2004, pursuant to my ruling at the hearing allowing him to rehabilitate his prior testimony. TR 40. Dr. Rasmussen reviewed

the depositions of Drs. Bellotte and Zaldivar. CX 8. He reasserted his belief that the miner has emphysema due to coal dust exposure. He also stated:

> Neither Dr. Bellotte nor Dr. Zaldivar commented on the fact that coal miners do, indeed, have a much higher incidence of interstitial fibrosis than that found in the general population. This was both [sic] simply stated that the authors of the McConnochie paper [citation omitted] did not propose an explanation for the increased incidence. Failure to assert known causative mechanism does in no way exclude coal mine dust as a causative factor in the increased incidence of diffuse interstitial fibrosis found in coal miners in the United States, Great Britain and France. It is also true that pathologists consider the diffuse interstitial fibrosis found in coal miners associated with deposition of coal pigment to be coal mine related, although that portion of diffuse interstitial fibrosis not associated with coal pigment is of uncertain significance.

Dr. Rasmussen also referred to his own article for the proposition that impairment in oxygen transfer and reduction in single breath diffusing capacity occurs as a consequence of pneumoconiosis, contrary to Dr. Zaldivar's statement.

CONCLUSIONS OF LAW

Entitlement to Benefits

This claim must be adjudicated under the Regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202–718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Subsequent Claim

The Claimant's work as a coal miner was within the State of West Virginia, which is located within the jurisdiction of the Fourth Federal Circuit. The Benefits Review Board applies the law as it is interpreted by the applicable Circuit. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989).

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. *See* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim, which is denied on the basis of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d) (2001). Under this regulatory provision,

according to the Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997–998 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

The Court of Appeals for the Fourth Circuit, which has jurisdiction over this claim, has followed the *Sharondale* approach. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd* 86 F.3d 1358 (4th Cir. 1996) (*en banc*). I interpret the *Sharondale* approach to mean that the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Circuit 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

The amended Regulations make clear that the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. 20 C.F.R. § 725.309(d)(2). In the denial of the miner's prior claim, it was found that he had pneumoconiosis but was not totally disabled. Therefore, my inquiry begins with an investigation of whether the newly submitted evidence establishes total disability.

Total Disability

The Claimant must show that his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the ALJ must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, then the ALJ must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on recon. en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable to this claim because there is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or a deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. A claimant may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies showing an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the bloodstream. 20 C.F.R. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

In the instant matter, none of the pre-bronchodilator or post-bronchodilator tests produced qualifying results. Accordingly, I find that Claimant has not established total disability pursuant to § 718.204(b)(2)(i).

Of the five blood gas studies of record, all of which were performed at rest, the July 7, 2003 and November 5, 2003 studies produced qualifying values. They encompass two of the three most recent studies, all conducted in 2003. I find them the most probative because the other two studies occurred in 1999 and 2001, respectively. More weight may be accorded to the results of recent blood gas studies over studies conducted earlier. *Schretroma v. Director, OWCP*, 18 BLR 1-17 (1993). I note that the intervening study ordered by Dr. Olson on July 22, 2003 was not qualifying, and if it were the last study of record, I would be inclined to consider the July 7, 2003 study anomalous. However, because the most recent study by four months also yielded qualifying results, I find that the blood gas study evidence establishes total disability pursuant to § 718.204(b)(2)(ii).

In addition, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b). Under this subsection, I must examine all the evidence of record "relevant to the question of total disability due to pneumoconiosis … with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201, 1-204 (1986). I must compare the exertional requirements of the Claimant's usual coal mine employment with a physician's assessment of the Claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once the miner has demonstrated that he is unable to perform his usual coal mine work, he has made a prima facie case of total disability; the burden of going forward with evidence to prove that the Claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined at § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The hospital records and Drs. Walker and Olson failed to address the issue of total disability. Dr. Bellotte opined that Claimant is totally and permanently disabled from

performing coal mine employment. Dr. Zaldivar and Dr. Rasmussen also found the miner to be totally disabled.

The medical opinion testimony addressing the issue of disability is unanimous that Claimant is totally disabled. The three physicians expressing an opinion possess excellent credentials. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). Their opinions are well reasoned and well documented. They are supported by the most recent blood gas study evidence, the Claimant's medical history, and his presenting symptoms. Therefore, I fully credit all three opinions. Consequently, I find that the evidence tends to establish total disability pursuant to § 718.204(b)(2)(iv).

After consideration of all the evidence under § 718.204(b)(2), like and unlike, I find the medical opinion testimony, as supported by the blood gas study evidence, to be the most probative. I rely on the medical opinion evidence because the opinions are unanimous on this issue. Support in the form of the objective blood gas study evidence strengthens my reasoning. Accordingly, I find that Claimant has established, by a preponderance of the evidence, that he is totally disabled. Thus, he has also demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d) (2001). As a result, all the evidence must be weighed to determine whether Claimant is entitled to benefits under the Act.

Existence of Pneumoconiosis

The Regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The Regulations' definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> Those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silico-tuberculosis, arising out of coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal-mine employment. *Id.* A claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320.

The Regulations provide four methods for finding the existence of pneumoconiosis: chest X-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant ahs pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)–(4). As there is no autopsy or biopsy evidence and Claimant is not eligible for the presumptions,[3] only chest X-rays, CT scans, and medical opinions can establish the existence of pneumoconiosis in his claim. In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

In the April 18, 1988 Decision and Order, Judge Marcellino found the existence of pneumoconiosis pursuant to the X-ray evidence. The evidence consisted of seven readings of five separate X-rays. The August 24, 1973 X-ray was found positive (category 1/0) by a physician whose name could not be deciphered. It was reread as negative by Dr. Gaylor, a B-reader and Board-certified radiologist. I consider this film negative, deferring to the superior credentials of Dr. Gaylor. *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984). The September 14, 1978 X-ray was found positive (category 1/1) by Dr. Kwak, a board-certified radiologist. It was not reread, so I consider this film positive. The December 1, 1980 X-ray was found to be consistent with occupational pneumoconiosis by Dr. Hayes, a B-reader. It was not reread, and I consider this film positive. The December 22, 1980 X-ray was found positive by Dr. Goerlich, who is a dually certified reader. I therefore consider this X-ray to be positive for pneumoconiosis. The August 29, 1984 X-ray was found positive by Dr. Daniel (category 2/2), but he possesses no special credentials for interpreting X-rays. Dr. Gaziano, a B-reader, read the same film as completely negative. I defer to his credentials and consider this X-ray negative. The most recent X-ray considered by Judge Marcellino was dated December 13, 1984. It was found positive (category 3/3) by Dr. Bassali, a dually certified reader. It was not reread, and I find this film positive for pneumoconiosis.

There are thirteen additional readings of nine separate X-rays submitted in conjunction with the subsequent claim. The December 13, 1999 X-ray was read by Dr. Shah as showing severe COPD and pulmonary fibrosis, but he did not link either condition to coal dust exposure. Therefore, I cannot consider this reading equivalent to pneumoconiosis. Dr. Shah is board-certified in radiology. The March 20, 2001, April 2, 2001, and October 23, 2001 X-rays were interpreted by Dr. Amin, a B-reader. He found severe COLD and diffuse honeycombing and interstitial fibrosis in both lungs. Once again, because Dr. Amin did not associate any of these conditions with coal mine employment, I do not find his readings equivalent to pneumoconiosis.

[3] Claimant is ineligible for the § 718.304 presumption because he has not been diagnosed with complicated pneumoconiosis. Claimant cannot qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant is ineligible for the § 718.306 presumption because he is still living.

The November 2, 2001 X-ray was read as positive (category 2/2) by Dr. Walker, who possesses no special qualifications for X-ray interpretation. It was confirmed as revealing category 2/2 disease by Dr. Hayes, who is both a B-reader and a board-certified radiologist. Dr. Hayes also noted areas of fibrosis in both lower zones. Dr. Bellotte, a B-reader, also interpreted this X-ray and found it positive for pneumoconiosis with a category 1/2 reading. Because the opinion of the reviewing physicians is unanimous that this X-ray shows pneumoconiosis, and because two of the readers are B-readers, with one also a Board-certified radiologist, I consider this film to be positive for the disease.

Dr. David Maki read the April 19, 2002 and March 28, 2003 X-rays. He is neither a B-reader nor a board-certified radiologist. He found significant lung disease, significant pulmonary fibrosis with COPD and emphysematous changes, but he did not relate any of these conditions to coal dust exposure. Consequently, I cannot consider either X-ray positive for pneumoconiosis.

Dr. Bellotte interpreted the July 7, 2003 X-ray as positive for pneumoconiosis, with a 1/2 reading. He once again noted pulmonary fibrosis, as well. Dr. Bellotte is a B-reader. This X-ray was reread by Dr. Wiot, a dually certified reader, who found the film negative for pneumoconiosis. Dr. Wiot noted interstitial disease in the mid and lower zones, with honeycombing in the left base. He added that pneumoconiosis is not a cause of basilar interstitial fibrosis, adding that pneumoconiosis invariably begins in the upper lung zones. Because Dr. Wiot's X-ray reading credentials exceed Dr. Bellotte's, I defer to his interpretation and consider this X-ray negative. *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984).

The final X-ray of record was taken November 5, 2003 and read by Dr. Zaldivar, who was not a B-reader at the time of his interpretation. He found the film negative for pneumoconiosis. Rather, he saw bullae and irregular opacities with the honeycombing of pulmonary fibrosis. Dr. Wiot also read this film, and, like Dr. Zaldivar, did not find pneumoconiosis. He made the same findings as when he read the July 7, 2003 X-ray. Consequently, I consider this X-ray negative.

In summary, there are a total of twenty-one readings of fifteen separate X-rays taken between August 1973 and November 2003. There are nine positive readings, six negative readings, and six other readings that cannot be considered positive for pneumoconiosis. There are two readings by Board-certified radiologists who are not also B-readers. Of those two readings, one is positive and the other cannot be interpreted as positive. There are seven readings by B-readers who are not board-certified radiologists. Of these readings, three are positive, one is negative, and three cannot be considered positive. Six were interpreted by dually certified readers, three of whom found them positive and three of whom found them negative. I conclude that Claimant has established, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Additionally, a determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a). Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately

documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 BLR 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report to be not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 BLR 1-1130 (1984). A medical opinion is not sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 BLR 1-368 (1983).

In connection with the original claim, the record contains the opinions of Drs. Daniel, Rertenwald and Hayes, and Jacobson. All found the existence of pneumoconiosis. In conjunction with the subsequent claim, Drs. Walker, Bellotte, Olson, and Rasmussen diagnosed pneumoconiosis. Only Dr. Zaldivar did not. I find the opinions of the physicians who found the existence of pneumoconiosis to be supported by the overall X-ray evidence. The opinions of Drs. Walker, Bellotte, Olson, and Rasmussen are well documented and reasoned. Drs. Bellotte and Rasmussen had the opportunity to review all the documentary evidence of record, thereby providing them with a broad base from which to draw their conclusions. Consequently, I place great weight on these opinions.

On the other hand, I discount Dr. Zaldivar's opinion on this issue because he stated that there was no evidence to justify a diagnosis of pneumoconiosis when, in fact, nine of the X-ray readings he reviewed were positive for the disease. This fact belies his conclusion. Consequently, I do not consider his opinion well reasoned, and I discount it.

The CT scan evidence shows a diagnosis of end-stage pneumoconiosis by Dr. Patel, and a reading of no pneumoconiosis by Dr. Wiot. Both physicians are Board-certified radiologists. However, Dr. Wiot opined that coal workers' pneumoconiosis is not a cause of basilar interstitial fibrosis, and I find this statement to be contrary to the medical article cited by Dr. Rasmussen. Dr. Rasmussen opined that it can be a cause and cited to an article that at least suggests further study of the issue. Even Dr. Bellotte allowed that there may be a connection between the two. For this reason, I do not find Dr. Wiot's CT scan interpretation to be as credible as Dr. Patel's. Therefore, I consider the CT scan evidence supportive of a finding of pneumoconiosis. I also find that the medical opinion evidence establishes the existence of pneumoconiosis.

Weighing all the evidence together, I find that the positive X-ray interpretations, when combined with Dr. Patel's CT scan reading and the overall medical opinion evidence, establishes the existence of pneumoconiosis.

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten yeas or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with thirty years of coal mine employment, is entitled to the rebuttable presumption at § 718.203. Moreover, based on the foregoing discussion, I find that Employer has not submitted sufficient evidence to rebut this presumption.

Total Disability Causation

Claimant must establish by a preponderance of the evidence that his total disability is due to pneumoconiosis. *Baumgartner v. Director, OWCP*, 9 BLR 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 BLR 1-4, 1-6 (1986) (*en banc*). The amended Regulations require that the pneumoconiosis be a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Section 718.204(c)(1) (2001) sets forth that pneumoconiosis is a substantially contributing cause of disability if it either (1) has a material adverse effect on the miner's respiratory condition or (2) materially worsens a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment. In *Tennessee Consolidated Coal Co. v. Director, OWCP*, 264 F.3d 602 (6th Cir. 2001), the Court of Appeals for the Sixth Circuit interpreted the "materially worsens" standard, finding that the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even absent any coal dust exposure would not preclude entitlement to benefits if pneumoconiosis "materially worsens" this condition. Furthermore, physicians are not required to precisely determine the percentages of contribution to total disability. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

Dr. Bellotte opined that Mr. Stephenson's total disability is due to coronary artery disease and congestive heart failure. He found no pulmonary or respiratory impairment related to pneumoconiosis. Dr. Olson did not address the etiology of the miner's disability but did express that he thought the Claimant's pulmonary fibrosis could be due to pneumoconiosis. Dr. Zaldivar felt that the Claimant was disabled due to pulmonary fibrosis unrelated to coal mine employment and coronary artery disease. Dr. Rasmussen opined that the miner's total disability is due to smoking, coal dust exposure, and interstitial fibrosis.

The opinions of the four physicians who examined Claimant in connection with his original claim must also be considered. Drs. Rertenwald and Hayes examined the miner in December 1980, and Dr. Jacobson evaluated him one month later in January 1981. The Claimant was still working as a coal miner at this time. Drs. Rertenwald and Hayes found no impairment, and Dr. Jacobson did not address the issue of impairment. Dr. Daniel saw the miner in August 1984, four months after he left coal mine employment. The physician found no evidence of significant pulmonary dysfunction and believed that the miner should be able to perform his usual work activities. Because these opinions are so remote in time—at least twenty years old—and pneumoconiosis can be progressive in nature, I place no weight on these early opinions. *See Bates v. Director, OWCP*, 7 BLR 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier).

Based on the opinions of Drs. Bellotte, Olson, Zaldivar, and Rasmussen, the key question is whether Claimant's pneumoconiosis has had a material adverse effect on his pulmonary fibrosis or whether his pneumoconiosis has materially worsened a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment, such as his cardiac disease.

While Dr. Olson is the miner's treating physician, having first seen him in 1999 and having treated him about every three to six months for a variety of ills, he did not express much understanding of pneumoconiosis. In fact, he stated in his deposition that he would defer to pulmonary specialists on any issues regarding that disease and others involving the pulmonary system. He testified that he did not know the cause of hypoxemia or whether pneumoconiosis is a latent and progressive disease. Thus, despite Dr. Olson's status as the miner's treating physician, I do not give his opinion controlling weight. 20 C.F.R. § 725.104(d). Furthermore, Dr. Olson stated that he relied upon the interpretations of those conducting X-rays and pulmonary function studies; he did not render his own opinion based on those results. For these reasons, I do not consider Dr. Olson's report to be well reasoned. Lastly, because Dr. Olson expressed his opinion in indefinite terms—"could be due to pneumoconiosis"—his opinion is entitled to less weight. *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Consequently, I place no weight on his opinion in regard to this issue.

Dr. Rasmussen's opinion is well documented. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). He is Board-certified in internal medicine and forensic medicine. These credentials lend some degree of credence to his determinations. He also reviewed all the medical evidence of record, thus providing him with a broad base of data from which to draw his conclusions. Because he is not Board-certified in pulmonary disease, I do not consider him to be as expert in the field of pulmonary medicine as Dr. Bellotte and Dr. Zaldivar. Moreover, he failed to mention the role the miner's significant heart disease (myocardial infarction, angioplasties, CABG, coronary artery disease) plays in his total disability and symptoms of respiratory impairment such as shortness of breath and coughing.

Dr. Rasmussen strongly relied upon the McConnochie article for his belief that pulmonary fibrosis is much more common among coal miners than those in the general population. In the face of the shared yet independent opinions of Drs. Bellotte and Zaldivar—that the article set forth that some coal miners have pulmonary fibrosis and these cases should be studied further—Dr. Rasmussen's defense of his reliance on the article is not altogether persuasive. However, the article does raise the possibility that coal mine dust exposure can cause interstitial pulmonary fibrosis. During his deposition, Dr. Rasmussen stated that failure to assert a known causative mechanism in no way excludes coal mine dust as a causative factor in the case of interstitial fibrosis in coal miners. I understand the Dr. Rasmussen to mean that, before labeling a disease process "idiopathic," a physician should rule out logical possible causes. In this case, Claimant has a thirty-year exposure to coal mine dust and has established the existence of pneumoconiosis through X-ray, medical opinion, and CT scan evidence. It is logical to conclude, as Dr. Rasmussen has, that the coal dust exposure has at least had a material adverse effect of the pulmonary fibrosis, even in light of his significant history of cardiac disease. Accordingly, I place great weight on Dr. Rasmussen's opinion.

I find Dr. Bellotte's opinion to be persuasive. He examined the miner, reviewed additional medical evidence, and maintains excellent credentials in the area of pulmonary disease. He explained how Claimant's pulmonary function studies are consistent with congestive heart failure and pulmonary fibrosis: impaired diffusion capacity with normal ventilation. Dr. Zaldivar bolstered this opinion. I note, however, that Dr. Bellotte conceded that a gas exchange abnormality can occur with pneumoconiosis, and this is consistent with Dr.

Rasmussen's opinion, in part. Dr. Bellotte also pointed out that some of the medications the miner is taking for his heart ailments can cause respiratory symptoms such as cough, wheeze, and dyspnea.

Dr. Bellotte also illustrated why the Claimant's symptoms and objective medical evidence are consistent with pulmonary fibrosis but not pneumoconiosis: (1) according to the CT scan, lesions are found in the bases of the lungs as opposed to the upper portion of the lungs; (2) the CT scan showed honeycombing; (3) the 1984 x-ray was negative; (4) there is no medical literature making a connection between pulmonary fibrosis and pneumoconiosis or coal mine employment; (5) repeated infections and congestive heart failure are reasonable suspects as the cause of the pulmonary fibrosis; and (6) normal pulmonary function studies long after the miner's 1984 retirement.

I find some fault with Dr. Bellotte's reasoning in that while the August 29, 1984 X-ray was found negative by Dr. Gaziano, a B-reader, a December 13, 1984 X-ray was found positive by Dr. Bassali, a dually certified reader. Moreover, the September 14, 1978 and two December 1980 X-rays were also interpreted as positive for pneumoconiosis. Furthermore, although the CT scan does show lesions in the bases of the lungs according to Dr. Wiot, it also revealed end-stage pneumoconiosis, according to Dr. Patel. Because these physicians share equal credentials, there is no reason to weigh Dr. Wiot's interpretation over Dr. Patel's. As Dr. Bellotte himself stated at his deposition, the medical literature allows for the possibility of a connection between coal dust exposure and pulmonary fibrosis, concluding that further study is warranted. When faced with this medical article, Dr. Bellotte also stated that perhaps he sees more IPF in West Virginia because of the large coal mining population. This statement acknowledges that there may be a nexus between the two. For these reasons, while I find Dr. Bellotte's opinion to be entitled to some weight, I do not place controlling weight on it.

Dr. Zaldivar is Board-certified in internal medicine and pulmonary disease. His expertise in pulmonary medicine merits deference. His opinion is well documented and he has also considered all the medical evidence of record, thereby providing him with a clear picture of the miner's health over time. Like Dr. Bellotte, he stated that honeycombing found on the X-rays and CT scan is consistent with pulmonary fibrosis and not pneumoconiosis. Both also asserted that a reduced diffusion capacity is typical of pulmonary fibrosis.

Dr. Zaldivar, however, is the only physician who opined that Claimant does not suffer from CWP. The Fourth Circuit has held that a medical opinion that finds that a claimant does not have CWP "can carry little weight" in assessing the etiology of the miner's total disability "unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon h[is] disagreement with the ALJ's finding as to either or both of the predicates . . . in the causal chain." *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). In this case, Dr. Zaldivar assumed the existence of pneumoconiosis and went on to state that his opinion regarding total disability causation would not change. However, Dr. Zaldivar strongly asserted that CWP never causes pulmonary fibrosis. Dr. Bellotte did not concur in this opinion, and I find that it is belied by the McConnochie article. For that reason, I place less weight on Dr. Zaldivar's opinion than on Dr. Bellotte's.

Based on the foregoing analysis, I find that Claimant has established, by a preponderance of the evidence, that pneumoconiosis is a substantially contributing cause of his disability in that he has shown that the disease has had a material adverse effect on his respiratory condition.

Conclusion

As Claimant has established all elements of entitlement, I conclude that he has established entitlement to benefits under the Act.

Date of Onset

In a case such as this, in which the evidence does not establish the month of the onset of total disability, benefits are payable beginning with the month during which the claim was filed. 20 C.F.R. § 725.303(d). In this case, Claimant filed the instant claim on August 21, 2001.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein, as no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to §§ 725.365 and 725.366 of the Regulations. A service sheet showing service upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of BEN L. STEPHENSON for black lung benefits under the Act is hereby GRANTED, and it is hereby ORDERED that ISLAND CREEK COAL COMPANY, the Responsible Operator, shall pay to Claimant, BEN L. STEPHENSON, all augmented benefits to which he is entitled under the Act, commencing August 1, 2001.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days of the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution